



## **Shriver Center Supplemental Comments on Path to Transformation 1115 Waiver**

**March 10, 2014**

Shriver National Center on Poverty Law previously submitted written comments on the Path To Transformation 1115 Waiver proposal as well as provided oral comments with a written copy at a public hearing on February 20, 2014. As noted in both sets of comments, the Shriver Center is generally supportive of the goals of the proposed waiver to improve health outcomes through care coordination; reduce unnecessary acute care and costs; and maximize federal financing for the Illinois Medicaid program including county and state health systems. The comments below supplement our prior comments and address several issues raised in the final proposal posted on February 10, 2014.

### **Cost Sharing**

In Section V Cost Sharing Aggregate Limits, the State proposes to waive consumer protections for the imposition of cost sharing on Medicaid recipients until such time as the State can improve its computer system to track these costs. (pp. 46-47) We object to any waiver of these provisions. The federal law is designed to inform consumers when they have reached their cost-sharing maximums and to protect consumers from providers who charge co-payments beyond maximum limits allowed. If the State does not have the capacity to track and inform consumers when they have reached these limits, then the state should not impose co-payments until that capacity is acquired. Beneficiaries do not have the means to track these costs on their own and federal law puts the burden on the State for that reason. To expect Medicaid recipients to be aware of their own out of pocket maximums which must be individually calculated based on a percentage of their family income; to track their co-payments until they reach that limit; and then to affirmatively inform their medical providers that they can no longer be charged is unrealistic and burdensome. Cost sharing has a chilling effect on consumers causing delays in necessary care because of fear and embarrassment over failure to be able to pay co-pays. See generally Families USA Fact Sheet citing the Rand Health Study, [http://familiesusa.org/sites/default/files/product\\_documents/Cost-Sharing-in-Medicaid.pdf](http://familiesusa.org/sites/default/files/product_documents/Cost-Sharing-in-Medicaid.pdf) and <http://www.cbpp.org/cms/index.cfm?fa=view&id=1938>.

The State should meet its burden to ensure that recipients know when their share is paid and they are no longer responsible to pay more.

In addition, in Section V Cost Sharing Non-Emergency Services Furnished in an Emergency Department, the State proposes to waive the requirement that it can only impose cost sharing on the use of an emergency department for non-emergency services if the hospital informs the patient of alternative care opportunities and refers the patient to a non-emergency setting where they would not have to pay a co-payment. This federal provision is intended to transition Medicaid patients who use the emergency room to receive non-emergency care to a community-based provider who could provide the same care in a non-emergency setting. Without these notice and referral procedures, Medicaid recipients who use the emergency room because they do not have access to or do not know of a non-emergency provider who they can go to are instead punished by being charged a co-payment without any assistance to find appropriate care. This is completely in opposition to Illinois' stated goals in this waiver proposal to improve health outcomes and reduce unnecessary costs by transitioning Medicaid populations into more appropriate coordinated primary care.

In addition, CMS has denied other states' waiver requests which included increased cost-sharing under an 1115 Waiver Proposal. Illinois already imposes cost sharing and should not be allowed to further burden Medicaid recipients under an 1115 Waiver by eliminating consumer notice, referral and tracking provisions. See <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf>

### **Inclusion of Domestic and Sexual Violence Screening and Counseling in Medicaid Funded Services**

We recommend that screening, counseling and treatment for domestic and sexual violence be included in the Medicaid reimbursable service package under this waiver. If a Medicaid recipient has experienced this type of violence, it will impact their health outcomes overall in the same manner as homelessness, trauma and mental illness. Therefore, domestic and sexual violence should be considered as a social determinant of health requiring access to integrated community-based domestic and sexual violence services along with physical health care services. In order to include screening for a history of domestic and sexual violence during a routine medical visit, it is recommended that domestic and sexual violence screening by health care professionals be covered in the Medicaid coverage package for all recipients. Although domestic violence screening and mental health treatment are included in the Essential Health Benefits and thus in the Alternative Benefit Package for Medicaid, the details on screening and treatment utilization guidelines are largely left up to the individual state. Illinois has a unique opportunity here to include and expand screening and treatment for these issues in the 1115 waiver to ensure that mental health and other health treatment

providers are able to bill Medicaid for screening and counseling services and that providers who provide these services will be included as an important health partner in the creation of managed care/care coordination entities. In doing so, Illinois should include, as reimbursable Medicaid services under this waiver, screening and treatment for all acts of domestic violence (as defined in Section 103 of the Illinois Domestic Violence Act, 750 ILCS 60/ by a household or family member as defined in Section 103 of the Illinois Domestic Violence Act) and all sexual offenses (as defined in the Illinois Criminal Code of 2012 Article 11 and Sections 12-7.3, 12-7.4, and 12-7.5.)

### **Provisions Relating to Private-Public Partnerships**

We note that two items in the draft waiver call for public private partnerships (in the Cook County Health and Hospital System DSRIP (pages 18 and 84-85) and the Regional Health Hubs proposal (pages 24 -25)). These provisions do not provide at this time adequate details for CMS or the public to assess whether the involvement of private entities into the provision of health services to Medicaid recipients will produce better and more efficient patient and public health outcomes. The use of private for profit entities paid for with public funds to provide and manage health care for Medicaid consumers should always receive very careful scrutiny. We urge CMS to approve of provisions in this waiver proposal that support the public health system in Cook County and in the rest of the State and to not approve any waiver provisions that will divert resources from or weaken the public health system.